HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Patient Name:___________________________________ Date of Birth: ________________________

I hereby consent to Tennessee Breast Care Center (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's healthcare operations. I also consent to Practice using or disclosing my protected health information to treatment activities provided by another health care provider health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Specific Records Expressly Included: I expressly authorize release of the following information for the purposes of treatment, payment and healthcare operations, it is part of my protected health information (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE TO RELEASE):

( ) All Patient Records ( ) History & Physical ( ) Radiology Reports ( ) Discharge Summary
( ) Laboratory Results ( ) Progress Notes ( ) HIV Test/Status ( ) Other________________
( ) Chemical Dependence/Substance Abuse/Drug/Alcohol ( ) Sexually Transmitted Diseases

Information Requested From:

Provider/Facility:____

Street Address:____

City/State/Zip:____ Fax:_________________________

Above records to be released to:
Provider Facility: Naomi Paschall, MD
Address: 100 Covey Dr. Suite 204
City/State/Zip: Franklin, TN 37067
Fax: 615-321-4977

These records are requested for the following reason:

( ) Continued Medical Care **( ) Other____**

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the use and disclosure allowed by this consent, as well as other rights I have regarding my protected health information.

____ ____
Signature of Patient or Personal Representative Name of Patient or Personal Representative

Date_____________________________________ Description of Representative's Authority:______________________

Witnessed By:_____________________________ Restriction to Dates/Episodes:_________________________________